United States Department of Labor
Employees' Compensation Appeals Board

A.R., Appellant	)	
and	)	**Docket No. 09-1060**
	)	**Issued: January 13, 2010**
DEPARTMENT OF THE NAVY, MARINE CORPS, Twenty Nine Palms, CA, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On March 4, 2009 appellant filed a timely appeal of a February 6, 2009 decision of the Office of Workers' Compensation Programs which affirmed the July 7, 2008 denial of his claim for compensation. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant met his burden of proof to establish that he sustained an occupational disease in the performance of duty.

FACTUAL HISTORY

On May 25, 2008 appellant, then a 40-year-old firefighter, filed an occupational disease claim alleging that he developed injury to his left shoulder and mid-thoracic area from wearing a self-contained breathing apparatus and lifting heavy amounts of weight at work. He first realized

that his condition was caused or aggravated by his employment activities on May 20, 2008. Appellant did not stop work.[1]

On June 6, 2008 the Office advised appellant of the factual and medical evidence necessary to establish his claim. It allowed him 30 days to submit such evidence. Appellant submitted an April 17, 2008 report from Dr. Ali Tahmouresie, a Board-certified neurosurgeon, who noted that appellant had a history of cervical spine and left shoulder pain with surgery on the left shoulder. Dr. Tahmouresie noted that appellant had been previously diagnosed with thoracic spinal fracture. A magnetic resonance imaging (MRI) scan of the cervical spine revealed degenerative changes. Dr. Tahmouresie indicated that a thoracic spine x-ray revealed reduced height of multiple levels, reflected a chronic and natural condition for appellant. He diagnosed possible osteoporosis and degenerative disc disease of the cervical spine.

In a July 7, 2008 decision, the Office denied appellant's claim, finding that he did not establish that the claimed medical condition related to his federal work duties.

Appellant requested a telephone hearing through his representative on July 15, 2008. He submitted treatment notes dated between December 22, 2006 and May 24, 2008 from Dr. Donna Alderman, an osteopath specializing in family medicine, who noted appellant's complaints of pain in his left shoulder, right hip and knee and administered injections to those areas. On May 24, 2008 Dr. Alderman noted that appellant appeared well and she examined his carpal tunnel syndrome. She assessed osteoporosis, old rib fracture and work-related injuries.

A June 13, 2007 report from Dr. Louis Stabile, a Board-certified orthopedic surgeon, noted that appellant's job as a firefighter required carrying heavy rope. Upon examination, Dr. Stabile noted that appellant's left shoulder revealed tenderness to some degree along the posterior border and humeral joint. He diagnosed left shoulder impingement syndrome, cervical spondylosis but no radiculopathy. Dr. Stabile opined that appellant's shoulder blade pain was due to degenerative disc disease. On July 12, 2007 he found clinical improvement status post injection of the left shoulder for advanced tendinitis and perhaps partial thickness tear of the anterior edge of the supraspinatus tendon.

In an October 18, 2007 report, Dr. James Bell, a Board-certified orthopedic surgeon, noted appellant's history of shoulder problems for a year. Upon examination, he found tenderness of the subacromial region and anterior aspect of the glenohumeral joint. Dr. Bell also found fairly good flexion, abduction with some limited external rotation and fairly good strength over the rotator cuff and deltoid. He diagnosed probable tear of the anterior labrum and left shoulder impingement. In an October 26, 2007 operative report, Dr. Bell diagnosed left shoulder impingement, labral tear and significant degenerative changes of the glenoid. He performed an arthroscopy of the left shoulder with debridement of labral tear, chondroplasty of the glenoid and subacromial decompression. In reports dated from December 14, 2007 to January 24, 2008, Dr. Bell noted that appellant underwent injections to his shoulder. He advised that appellant had full range of motion and normal neurological and circulatory examinations. On March 27, 2008 Dr. Bell noted that appellant had a history of left shoulder degenerative changes and that he

[1] Appellant subsequently noted that he injured his arm during swift water rescue training in September 2006 and the condition continued over time as he performed his work duties.

underwent an arthroscopic debridement in October 2007. He noted that appellant's left shoulder had no tenderness to palpation, good range of motion, and normal motor, neurological and circulatory examinations. Dr. Bell stated that appellant's right hip had tenderness in the groin area and fairly good range of motion. X-rays revealed dysplasia of the right hip but good maintenance of the joint space and no evidence of significant degenerative changes. Dr. Bell found left shoulder status post arthroscopic debridement, right hip dysplasia with symptoms more consistent for adductor tendinitis.

On July 14, 2008 Dr. Valerie Carpenter, a chiropractor, reviewed appellant's history of injury and summarized the diagnostic tests and treatment sought. She noted ordering cervical spine x-rays on December 18, 2006, from which degenerative disc disease at C5-6 and C6-7 was found. Dr. Carpenter stated that April 14, 2008 x-rays of the thoracic spine revealed reduced bone density and partial compression of several mid-thoracic vertebral bodies. She recommended that appellant take time off work to recuperate from injuries sustained at work, including major trauma, repetitive stress, exacerbations and remissions of pain. Dr. Carpenter noted that the heavy lifting, climbing and physical exertion of appellant's job-induced stress on his spine, discs and supporting musculature. She opined that appellant's areas of pain and dysfunction were the direct result of injury sustained as a firefighter. Dr. Carpenter stated that the type of traumatic injury appellant sustained resulted in tearing in the soft tissues, ligaments and muscle fibers resulting in inflammatory healing response which develops into scar tissue and fibrosis that may cause exacerbated symptoms, accelerated spinal degeneration and arthritis changes. She advised that appellant's spine was starting to deteriorate faster than it could heal due to repetitive stress and physical exertion from his job.

On July 15, 2008 Dr. Tahmouresie noted appellant's complaint of cervical and scapular pain. He summarized the history of treatment and present symptoms. He diagnosed osteoporosis, old compression fractures of the upper thoracic area and cervical spondylosis. Dr. Tahmouresie opined that appellant's osteoporosis and compression fractures were common for this disease. He also opined that a person with osteoporosis could easily sustain spinal compression fractures "during hard work like fire fighting." Dr. Tahmouresie further opined that it was "probable" that ongoing and continuous trauma to the cervical spine caused appellant's cervical degenerative disc disease. In an August 14, 2008 report, he diagnosed cervical spondylosis. Dr. Tahmouresie performed three trigger point injections. He noted a history of cervical spine pain and newly diagnosed winging scapula on the left side. Dr. Tahmouresie also noted recently developed pain with significant tenderness of the upper left trapezius area and left medial scapular area.

On August 26, 2008 Dr. Reza Nazemi, a Board-certified neurologist, noted that appellant developed severe left shoulder and neck pain after returning from training camp two years prior. He also noted that appellant complained of chronic left shoulder pain since undergoing left rotator cuff repair. Dr. Nazemi conducted an electromyogram (EMG) which revealed mild bilateral entrapment neuropathy at the wrists (carpal tunnel syndrome) and mild left ulnar entrapment neuropathy at the elbow (cubital tunnel syndrome). He also found clinical evidence of a lesion of the left long thoracic nerve root that was not confirmed by the EMG.

Appellant submitted witness statements from colleagues who attended rescue training with him and observed that he struggled with pain throughout the training.

On November 13, 2008 a telephone hearing was held at which a hearing representative agreed to hold the record open for 30 days to allow for the submission of additional medical evidence. Appellant submitted a January 24, 2007 report from Dr. Shahin Etebar, a Board-certified neurosurgeon, who advised that appellant's left shoulder soreness, occasional left hand paresthesias and left suprascapular pain began nine months prior. Dr. Etebar noted that appellant's left hand paresthesia was brought on with compression of the elbow or with flexion of the elbow for prolonged periods. MRI scans of the shoulder and cervical spine revealed left shoulder bursitis and tendinitis, cervical spondylosis and degenerative disc disease. Dr. Etebar diagnosed superimposed ulnar neuropathy and possible medial neuropathy at the wrist. On February 21, 2007 Dr. Nazemi performed an EMG and found mild left median entrapment neuropathy at the wrist and no evidence of cervical radiculopathy or diffuse neuropathic process.

In a February 6, 2009 decision, a hearing representative affirmed the July 7, 2008 decision finding insufficient medical evidence to establish that appellant's medical conditions related to his federal work duties.

LEGAL PRECEDENT

An employee seeking benefits under the Federal Employees' Compensation Act has the burden of establishing the essential elements of his or her claim, including the fact that the individual is an "employee of the United States" within the meaning of the Act; that the claim was filed within the applicable time limitation; that an injury was sustained while in the performance of duty as alleged and that any disability and/or specific condition for which compensation is claimed are causally related to the employment injury. These are the essential elements of each and every compensation claim regardless of whether the claim is predicated on a traumatic injury or an occupational disease.[2]

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit the following: (1) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; (2) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant.[3]

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on whether there is a causal relationship between the employee's diagnosed condition and the compensable employment factors. The opinion of the physician must be based on a complete factual and medical background of the employee, must be one of reasonable medical certainty,

[2] *J.E.*, 59 ECAB ___ (Docket No. 07-814, issued October 2, 2007); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[3] *D.I.*, 59 ECAB ___ (Docket No. 07-1534, issued November 6, 2007); *Roy L. Humphrey*, 57 ECAB 238 (2005).

and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the employee.[4]

ANALYSIS

The record establishes that appellant's position as a firefighter requires wearing a self-contained breathing apparatus and lifting heavy weight. Appellant has not, however, provided sufficient medical evidence to establish that a diagnosed left shoulder and back condition are causally related to his employment activities.

In the July 15, 2008 report, Dr. Tahmouresie diagnosed osteoporosis, old compression fractures of the upper thoracic and cervical spondylosis. He opined that a person with osteoporosis could easily sustain spinal compression during fire fighting. Dr. Tahmouresie also opined that it was "probable" that ongoing trauma to the cervical spine could cause appellant's cervical degenerative disc disease. He provided only a general opinion attributing osteoporosis and spinal compression to fire fighting. Dr. Tahmouresie did not specifically explain how appellant's osteoporosis condition was caused or aggravated by the particular duties or exertions in his job as a firefighter. His report, without sufficient rationale to explain the basis of his opinion and the term "probable," makes his opinion on causal relationship equivocal.[5] Dr. Tahmouresie's other reports did not specifically address how appellant's work duties caused or aggravated a diagnosed medical condition.[6]

On May 24, 2008 Dr. Alderman diagnosed osteoporosis, old rib fractures and work-related injuries. However, she did not identify any specific work-related injuries or explain how they were caused or aggravated by appellant's duties as a firefighter. The Board has held that a medical opinion not fortified by medical rationale is of little probative value.[7] None of Dr. Alderman's other treatment notes addressed the issue of causal relationship.

In the June 13, 2007 report, Dr. Stabile noted that appellant's job required carrying heavy rope. He diagnosed left shoulder impingement syndrome and cervical spondylosis. Dr. Stabile did not specifically address the issue of causal relationship or address whether carrying heavy rope caused or aggravated appellant's diagnosed condition. Similarly, on August 26, 2008 Dr. Nazemi noted that appellant sustained severe left shoulder and neck pain after attending training camp for work two years prior and diagnosed cubital and carpal tunnel syndrome.

[4] *I.J.*, 59 ECAB ___ (Docket No. 07-2362, issued March 11, 2008); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

[5] *Kathy Kelley*, 55 ECAB 206 (2004) (the Board has held that opinions such as, the implant "may have ruptured" and that the condition is "probably" related, "most likely" related or "could be" related are speculative and diminish the probative value of the medical opinion).

[6] *S.E.*, 60 ECAB ___ (Docket No. 08-2214, issued May 6, 2009) (medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship).

[7] *George Randolph Taylor*, 6 ECAB 986, 988 (1954).

Dr. Nazemi did not, however, provide an opinion on causal relationship or relate the training camp experience to appellant's left shoulder and neck condition.[8]

Appellant also submitted reports from Dr. Bell but he did not specifically address whether any of appellant's diagnosed conditions were caused or aggravated by his employment duties. Likewise, Dr. Etebar offered no opinion on causal relationship as he did not address whether the onset of appellant's conditions was caused by his work duties. As noted, medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[9]

The record also contains a July 14, 2008 report from Dr. Carpenter, a chiropractor, supporting that appellant's work duties caused or aggravated his claimed conditions. While Dr. Carpenter noted reviewing x-rays, she did not diagnose a spinal subluxation based on her review of x-rays. Under the Act, the term "physician" includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.[10] Without diagnosing a subluxation based on review of an x-ray, Dr. Carpenter is not a "physician" under the Act and her report has no probative medical value.[11]

Consequently, appellant has not submitted sufficient medical evidence to establish a causal relationship between his diagnosed conditions and his duties as a firefighter.

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that he sustained an occupational disease in the performance of duty.

[8] *C.B.*, 60 ECAB ___ (Docket No. 08-1583, issued December 9, 2008) (the weight of the medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion).

[9] *Supra* note 6.

[10] *See* 5 U.S.C. § 8101(2); *Mary A. Ceglia*, 55 ECAB 626 (2004).

[11] *See Isabelle Mitchell,* 55 ECAB 623 (2004).

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decisions dated February 6, 2009 and July 7, 2008 are affirmed.

Issued: January 13, 2010
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board